

Providing Treatment,
Restoring Hope

AIDS  **RELIEF**SM

FINAL REPORT

AIDSRelief, a five-member consortium funded through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), supported rapid scale up of HIV care and treatment services for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. Over nine years, the program served more than 700,000 people, including nearly 400,000 who enrolled on antiretroviral therapy through 276 health facilities.



Working largely through rural facilities, AIDSRelief established basic packages of care and treatment that exceeded what many thought possible in a resource-constrained environment. Instead of merely offering HIV tests and dispensing medicine, AIDSRelief helped health workers to identify and manage treatment failure or other adverse drug events; to diagnose, treat, and prevent opportunistic infections such as tuberculosis or pneumonia; and to provide patients with adherence counseling and support, empowering them to effectively manage their own treatment.

AIDSRelief consortium partners included Catholic Relief Services as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children's AIDS Fund as a key sub-grantee, supporting sites in three countries.



We would like to dedicate this report to AIDSRelief's patients, especially those who braved stigma, discrimination, and other hardships to visit the health facilities for testing and treatment. This is their story. They not only regained their health, but also gave hope and courage to many others. Their dedicated participation contributed to the success of the AIDSRelief and PEPFAR programs in scaling up treatment and expanding services to those most in need.

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When the first PEPFAR programs launched in 2004, many people did not believe it was possible to deliver high-quality, sustainable HIV treatment in low-resource settings—ART was too complicated, the environment too risky, and the patients faced too many challenges. Others feared the long-term financial commitment was not sustainable. Over the next nine years, AIDSRelief and other PEPFAR implementing partners transformed HIV care and treatment in focus countries, exceeding all expectations.

Operating primarily through rural facilities struggling to reach underserved populations, AIDSRelief delivered HIV care and treatment to more than 700,000 people in ten countries, including nearly 400,000 who enrolled on antiretroviral therapy (ART). This report outlines key outcomes and lessons learned during the nine-year program and describes approaches and methods that contributed to its success.

HIGHLIGHTS INCLUDE:

- » Durable viral suppression: In the seven AIDSRelief country programs where viral load surveys were conducted, the average viral suppression proportion—the gold standard for treatment success—was 88.2%, a rate comparable to or better than those seen in industrialized countries.¹
- » Strengthened human resources: More than 30,000 participants—doctors, nurses, pharmacists, and other health care workers—attended training sessions that built and strengthened their skills to provide high-quality HIV services.
- » Contributed to national guidelines: The AIDSRelief consortium was the first PEPFAR implementer to campaign widely for the use of tenofovir-based first-line regimens and one of the first to advocate for earlier ART initiation, measures which have now been recommended by WHO and adopted as standard guidelines in many countries. In most countries, AIDSRelief was also a principal contributor to prevention of mother-to-child transmission (PMTCT) guidelines, advocating for the most effective regimens which greatly reduce infections in children and keep their mothers healthy.

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¹ The CDC estimates that of U.S. patients linked to care and on ART, 77% had a suppressed viral load at their most recent test. See Morbidity and Mortality Weekly Report, December 2, 2011 / 60(47);1618–1623. Another recent U.S. study found 82% viral suppression in the highest cohort. See Dombrowski, JC et al. An encouraging HIV care cascade: anomaly, progress or just more accurate data? Twentieth CROI conference, Atlanta. Abstract 1027. 2013.

HIGHLIGHTS *continued...*

- » Expanded treatment: AIDSRelief leveraged the reach of faith-based health networks to complement and expand the reach of the public health systems into underserved communities. By 2009, about 15% of Ugandans on ART were receiving treatment through AIDSRelief-supported facilities. In Guyana, AIDSRelief supported 30% of adults in HIV care and treatment programs.
- » Increased use of accurate, timely data: AIDSRelief facilities developed a culture of evidence-based decision making, analyzing patient and program data and using the information to make informed decisions that addressed gaps in program operations and services.
- » Transition to local partners: AIDSRelief transitioned management of its care and treatment programs to local partners while maintaining high-quality service. Fourteen local partners in eight countries went on to secure new PEPFAR grants to manage the care and treatment programs established through AIDSRelief.
- » Reliable supply chain: AIDSRelief built robust supply chain mechanisms to ensure a continuous supply of medicines and other essential products. There were no stock-outs of AIDSRelief supplies during the program.



2 AIDS Epidemic Update, December 2004. UNAIDS.

OUR CALL TO ACTION



Though the context varied, most AIDSRelief country programs launched in 2004 facing health systems struggling under the burden of HIV and AIDS. At best, treatment was prohibitively expensive and inconsistent; more often it was virtually nonexistent. In fact, only about 440,000² people in low- and middle-income countries were receiving treatment. ART stood as a stark example of global health inequity, as lifesaving medications and quality care were widely available only to those living in wealthy countries.

With support from the newly-established PEPFAR, AIDSRelief brought together an experienced group of international experts working hand-in-hand with local partners to ensure that the skills and systems were in place to support a quality care delivery system: Catholic Relief Services (CRS) as prime grantee, the University of Maryland School of Medicine Institute of Human Virology (IHV) as technical lead for clinical care and treatment, Futures Group as lead agency for strategic information, IMA World Health and Catholic Medical Mission Board as

“Seldom has history offered a greater opportunity to do so much for so many.”

George W. Bush,
State of the Union Address,
January 28, 2003

implementing partners, and Children’s AIDS Fund, a key sub-grantee supporting sites in three countries.

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An interdisciplinary and comprehensive health systems strengthening approach was essential to fulfill AIDSRelief’s commitment to treating patients at scale and achieving durable viral suppression in a manner that could be sustained and owned by local partners. AIDSRelief established basic packages of care and treatment that exceeded what many thought possible in mostly rural, resource-constrained environments. In the process, it transformed the lives of more than 707,000 people. (See Annex 1 for a breakdown of patient enrollment in each country.)

EXCEPTIONAL TREATMENT



AIDSRelief’s treatment model centered on the belief that long-term efficacy and sustainability of treatment depends on using evidence-based strategies and comprehensive evaluation to guide both scale up and technical assistance. As HIV treatment expands and patients remain on therapy longer, it is imperative to ensure that programs are not compromised by the overwhelming demand for rapid expansion.

In wealthy countries, patients have many treatment options and can progress through numerous drug regimens as needed. However, in low-resource settings there are fewer options and the sustainability of ART programs hinges on first-line regimens. With millions of people in AIDSRelief countries eligible for treatment but limited budgets for scale up, it was critical to maintain patients on their first-line regimens as long as possible. Success hinged on three key considerations: regimen choice, treatment strategy, and adherence. Careful planning and robust support systems are needed to help patients stay on the most appropriate medications for the long term.

In each country program, AIDSRelief was an influential contributor to developing and adapting national care and treatment guidelines. The AIDSRelief consortium was the first PEPFAR implementer to campaign widely for the use of tenofovir-based first-line regimens, which are highly effective, have

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PEPFAR: From Emergency Response to Sustainable Development

The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) was launched in 2004 as response to the global HIV epidemic. The largest commitment by any nation to combat a single disease internationally, PEPFAR provided funding and technical expertise through implementing partners such as AIDSRelief, with emphasis on 15 focus countries. With the U.S. Congress’s reauthorization of PEPFAR in 2008, programming shifted from externally-led emergency relief to strengthening health systems and building a sustainable response wholly owned by each host country.

AIDSRelief countries

Africa



Caribbean



fewer side effects and are less likely to bring about drug resistance in patients. This approach was cost-effective in the long run, as patients did not progress to more expensive second- and third-line medications. AIDSRelief was also a strong voice for maternal-child health, advocating for the most effective regimens for pregnant women and their children. Some countries were reluctant to adopt the recommendation to put all HIV-infected pregnant women on a triple ARV regimen until they finished breastfeeding their babies.³ These countries had concerns about expense and feasibility, but AIDSRelief-supported sites provided women with this treatment and the superior patient outcomes influenced policy changes in countries including Nigeria and Uganda. This recommendation is now widely accepted around the world and has prevented millions of new HIV infections in children.

AIDSRelief was also one of the first implementers to advocate a strategy of beginning treatment earlier. In the absence of widespread treatment, many countries prioritized ART for the sickest patients. But AIDSRelief studies showed that patients who began treatment earlier—with higher CD4 counts—had greater treatment success. Overall, it is more cost-efficient to enroll patients earlier and treat healthier patients, who are less likely to need expensive treatment for opportunistic infections. National policies have evolved along with the evidence, and this approach has now been adopted as standard in many countries.

AIDSRelief country programs supported diagnosis, care, and treatment services for children and adolescents, steps that were reflected in the program's high overall pediatric enrollment of 8.3% and extremely low pediatric mortality of just 2.7%. To best care for HIV-positive infants, AIDSRelief was among the first PEPFAR implementing partners to create a comprehensive dosage schedule for pediatric ARVs and to advocate for and begin treatment of all infants infected with HIV regardless of CD4 count or clinical staging.

This commitment led to important pediatric treatment successes. For example, AIDSRelief Ethiopia's percentage of pediatric ART patients was more than twice the national average (nearly 14% versus 6%). In Kenya, 15% of the nation's total pediatric ART patients were from AIDSRelief facilities.

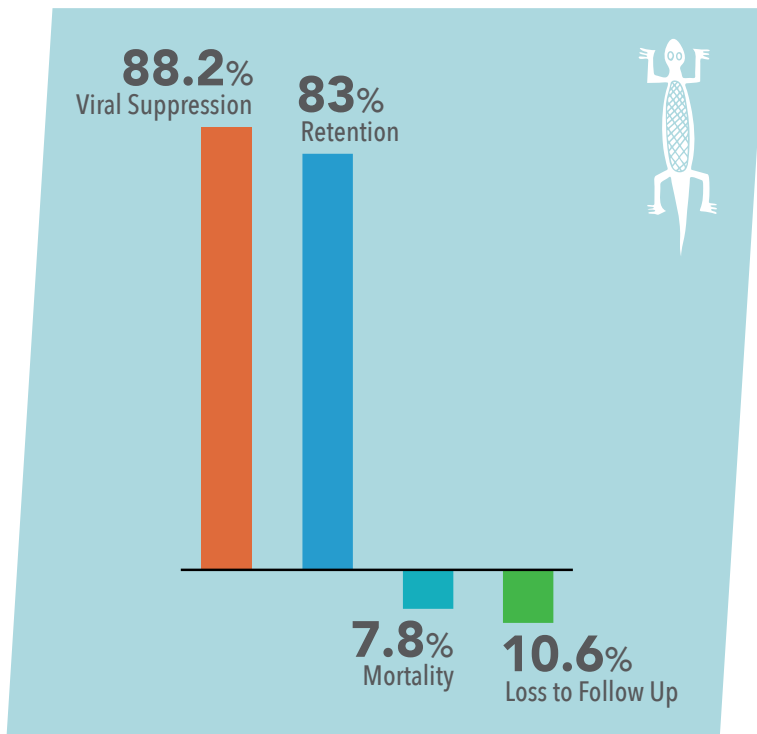
Finally, AIDSRelief found that the most important variable in successful treatment is the care delivery system. Patient adherence—and the support provided

"I would have died more than ten years back. And I have survived because of the project. I can see my daughter because of the project. I can stay in [my house] because of the project. And I believe I'm going to live the best kind of life, because I'm okay! I live like any other person. Life is so good to me."

Maresa, AIDSRelief Kenya
client since 2004

³ See WHO's April 2012 Programmatic Update: Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants.

By the Numbers⁴



to ensure it—was considered a therapeutic intervention and was integrated into the patient’s clinical treatment. Through intensive treatment preparation, adherence counseling, highly supported treatment initiation with peer-supported home visits, and community involvement, AIDSRelief support networks helped patients adhere to their treatment plans and reduced treatment failure. As a result, AIDSRelief has documented extremely low loss-to-follow-up and high viral suppression—vital measures of program success—throughout all nine years.



Engaging Communities to Improve Adherence

Chikuni Mission Hospital, in rural Zambia, has consistently maintained extremely low loss to follow-up rates throughout the program, among the lowest in all 276 AIDS-Relief facilities. Because adherence has been well-documented as a link to long-term viral suppression, the hospital monitors loss to follow-up as a secondary measure to track patient adherence.

In late 2008, loss to follow up, was at an impressively low 1.2%. Nonetheless, the staff developed a comprehensive, community-based strategy to reduce it further by re-engaging missing patients. Specific interventions included:

- » Support groups at 21 outreach centers
- » A community radio program focused on HIV
- » Outreach programs in schools and villages
- » Education programs for community leaders
- » A review of patient files
- » Adherence counseling at all pharmacy pickup appointments

Within eight months, loss to follow-up was below 1%.

⁴ Rates are derived from survival (time to event) analysis. At each time period, the probability of ‘survival’ is calculated, e.g., Retention on ART is calculated as: number still on ART / (number at the beginning of time period – number care ended during the time period). These ‘survival probabilities’ are then cumulated (multiplied) over several time periods. For instance, 12m retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.



Building a sustainable approach to HIV care and treatment requires comprehensive and timely access to clean, complete, and accurate data. But when AIDSRelief began, most health facilities were not computerized; patient records were maintained on paper forms. In some countries the

clinics maintained no records at all; instead, patients were responsible for bringing their own paper records to each appointment. AIDSRelief introduced comprehensive electronic medical records and helped its local partners build the skills to collect and analyze data regularly. This enabled staff to make informed decisions about how to improve the delivery of care.

AIDSRelief's activities were guided by three core goals:

- » ADDRESSING NEEDS — ensuring that partners have the equipment, staff, training and systems in place to meet the needs of all AIDSRelief patients, staff and facilities.
- » DEVELOPING CAPACITY — improving the ways in which partners collect, manage and use data so that program and patient monitoring is comprehensive and gaps in services are addressed earlier and more effectively.
- » ENSURING SUSTAINABILITY — empowering partners to gain increasing autonomy in evaluating and addressing their own needs, improving their systems and planning for the future.



This focus on strategic information provided decision-makers at the national and clinic level with high quality, usable data while developing the capacities of local partners to manage information. AIDSRelief teams worked with facility staff to extract meaningful information through statistical analysis and linked clinicians and data managers through combined

trainings, assessments, evaluation meetings, and other activities for continuous quality improvement. The result of these efforts was a paradigm shift: clinicians, data managers, and administrators grew to appreciate and seek out data to inform both clinical and administrative decisions.

Leveraging the Power of Faith-Based Networks

Faith-based health networks are essential stakeholders in the global HIV response, particularly in Africa. In Kenya and Tanzania, for example, it is estimated that about 40% of health care is delivered by faith-based organizations.⁵ In rural Zambia the figure rises to 60%. In such areas, faith-based health facilities have been providing much-needed health services for fifty years or more, making them trusted members of the community. In very rural communities, these facilities play a vital role in offering high-quality care in remote rural communities.

AIDSRelief built on the extensive reach of faith-based health networks (including Christian and Muslim organizations) to assist the most underserved populations with HIV care and treatment. Across the ten country programs, the majority of AIDSRelief partner facilities were affiliated with faith-based networks. These networks enabled AIDSRelief to leverage community linkages, develop highly effective community support mechanisms, and reach patients at the household level.

⁵ U.S. President's Emergency Plan for AIDS Relief (2012). A Firm Foundation: The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. Washington: U.S. Department of State. pepfar.gov/documents/organization/195614.pdf

Continuing, Locally Owned Education

In 2004, most developing countries had limited clinical capacity to manage the HIV epidemic. Physicians were dedicated to helping the increasing number of patients, but few had advanced training in infectious diseases such as HIV and most had little if any experience with the new classes of antiretroviral medications. Therefore, AIDSRelief expanded beyond direct technical assistance to build programs to train the next generation of HIV physicians who would maintain excellent patient outcomes. These highly trained professionals are poised to become tomorrow's instructors and mentors. For example:

- » AIDSRelief Zambia worked with the Ministry of Health and General Nursing Council and the University of Alabama to establish a one-year diploma program for nurse practitioners. With University of Zambia, University
- Teaching Hospital, and the Ministry of Health, AIDSRelief also established an 18-month Masters of Science program in HIV medicine.
- » AIDSRelief Nigeria advocated with the National Nursing Council to include HIV care and treatment in nursing school curriculums, which AIDSRelief subsequently helped to develop.
- » AIDSRelief Rwanda supported 10 clinicians to acquire Expert Certifications conferred by the American Academy of HIV Medicine.
- » AIDSRelief Haiti partner the University of Maryland School of Medicine established the country's first postgraduate medical education program of its kind at the University of Notre Dame Haiti.



Electronic Information Systems

AIDSRelief supported existing and established new health management information systems as appropriate for each country's context. In countries with established systems, AIDSRelief provided support and training, and helped improve technology for existing systems. Where electronic systems did not exist, AIDSRelief developed and implemented IQSolutions, a suite of electronic tools designed to provide a comprehensive, computer-based patient and data management system to match the paper system.

AIDSRelief installed IQSolutions in facilities in Guyana, Kenya, Nigeria, Rwanda, Tanzania and Uganda to facilitate high-quality, long-term patient care and to promote information collection and management. With this system, AIDSRelief pioneered and expanded the use of patient level outcomes to assess and evaluate treatment sites and national programs, and to provide data driven continuous quality improvement programs for supported facilities. In Uganda alone, the systems manage records for more than 80,000 patients, and AIDSRelief Kenya's information system held one of the largest validated data sets in the country. In 2010, a WHO evaluation rated IQCare as one of the best health management information system in Kenya and awarded a grant to Futures to help establish Kenya's national HMIS. Today IQCare is one of three products that Kenyan facilities can choose from.



A health systems strengthening approach was critical to AIDSRelief's success. In low-resource settings, HIV care and treatment programs require building not only clinical skills but also

technical expertise in areas such as strategic information, grants management, community outreach, and supply chain management. Recognizing that strong health systems were the key to sustainable HIV care, AIDSRelief invested heavily in helping its local partners to develop financial, material, technical and human resources through a continuous process of capacity enhancement and improvement. The ultimate goal was to build capacity of local partners to assume primary responsibility for HIV care in their facilities and communities.

Infrastructure and Equipment

A critical component of sustainable care is ensuring that sufficient physical resources are in place at each health facility to create a suitable setting for sustainable health care. Based on each facility's needs, AIDSRelief funded and managed refittings of the physical structure at selected sites, purchased essential equipment, and encouraged integration of HIV and non-HIV services when appropriate so that facilities could leverage the improvements for all patients. Facilities now have improvements such as infection control measures in laboratories and clinics, private areas for patients receiving HIV test results or adherence counseling, adequate space for co-located HIV and tuberculosis services, and more readily accessible CD4 and blood chemistry testing machines for monitoring patients.

Laboratory Strengthening

AIDSRelief was an early advocate of giving patients access to basic safety labs and CD4 counts before beginning ART. To this end, the program made great strides in strengthening human and material resources at laboratories and establishing laboratory services at supported facilities throughout each AIDSRelief country. AIDSRelief worked within national guidelines—



"This project has laid the foundation for a strong, sustainable healthcare delivery mechanism in Kenya, in the region, and in Africa. First by demonstrating how it is done, how it can be done. How resources can be used to deliver better health by transitioning to local organizations."

Dr. Jared Mecha, University of Nairobi

advocating for change when necessary—and upgraded or changed laboratory services as appropriate when national policies were revised or patient loads increased. Typical laboratory improvements under AIDSRelief included refitting infrastructure to support infection prevention and to create adequate workspace for staff, purchasing essential equipment (including site-specific solutions such as solar power where necessary), and strengthening capacity to ensure effective use of the equipment.

In many countries, AIDSRelief pioneered the clinical application of low-level but reliable manual CD4 enumeration technologies, simple dry chemistry, LED microscopy, ELISA-based viral load technology,



cryptococcal antigen (CrAg) testing, laboratory safety and waste disposal, and eventually quality assurance mechanisms. In addition, AIDSRelief delivered upwards of 200 training sessions for more than 1,500 laboratory workers globally, covering critical skills such as good phlebotomy and waste management practices, CD4 platform use, ART monitoring, and acid-fast bacillus (AFB) microscopy for tuberculosis.

Pharmaceutical and Supply Chain Management

Access to medicines and commodities such as lab reagents or clean needles for drawing blood is the cornerstone of successful HIV care and treatment and requires a high functioning supply chain and competent, trained pharmacy staff. Despite the vast rural areas covered by the program and the tremendous volume of medicines distributed, AIDSRelief was able to ensure the availability of medicines and commodities at all sites with no stock-outs while AIDSRelief staff managed the supply chain.

As in other technical areas of the program, needs-based training and accompaniment were hallmarks of capacity building among supply chain and pharmaceutical management staff. Prior to AIDSRelief, most supported

pharmacies lacked the physical resources to properly store and manage medicines. Through refittings, the facilities now have shelving, pallets, reliable power sources, and air conditioners to properly maintain stock and private dispensing areas for confidential patient counseling. Since AIDSRelief encouraged all supported facilities to integrate their pharmacies, these systems and improvements can help entire facilities function more effectively.

Quality Improvement

AIDSRelief placed significant emphasis on quality, supporting facilities to establish site-level continuous quality improvement (CQI) committees that met monthly and discussed challenges. With electronic and paper tools to collect data and by making small changes, one at a time, and analyzing the results, facilities maintained and improved service quality and took ownership of the process. Because of the enormous amount of useful data already collected, AIDSRelief emphasized data quality and prompt feedback of information. The results were remarkable. For example:

- » In Rwanda, a routine monthly report revealed that a striking number of patients were missing their CD4 appointments. Staff brainstormed and

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implemented responses to the problem. Within five months, dedicated appointment calendars at each site and synchronized CD4 and ART refill appointments caused the number of missed appointments to drop by 8.3%.

- » Staff were determined to improve the flow of patients through a facility in Kenya. After analyzing the problem, managers increased staff at the triage point (identified as a bottleneck) and staggered patient appointments throughout the day. As a result, the average wait-time decreased from six hours to less than two hours and providers worked more efficiently with a steady flow of patients.
- » Similar small tests of change and a focus on quality improvement reduced mortality by 50% (from 15 to 7 deaths per month) in Zambia's Wusakile hospital from 2008 to 2010. Circle of Hope clinic reduced patient waiting time from three hours to one hour, in just three months (October to December 2010).



Assessing Capacity for Sustained Care and Treatment

As AIDSRelief programs moved toward transition, it was apparent that program managers needed a specialized tool to assess each health facility's overall capacity to deliver a consistent and sustainable standard of HIV care and treatment. The Site Capacity Assessment (SCA) Tool was developed for both routine program monitoring and supporting the long-term sustainability of local partner health facilities.

The SCA Tool does not assess program outcomes; rather, it assesses the capacity of program operations and identifies areas in need of strengthening as well as areas of excellence that may exemplify best practices. Results from site capacity assessments provide a clear picture of the site's needs across clinical, strategic information, and management and finance areas, and allows facilities to prioritize technical assistance with greater emphasis given to low-scoring areas that require more attention.

AIDSRelief provided training for local partners, host country governments and other stakeholders to continue to use the SCA tool after the program transitioned to local ownership. By conducting twice-yearly assessments, they are able to maintain the standard needed for long-term sustainability.



"Before CQI the data was only used for reporting. We never used our own data. And after CQI now we realize the importance of that. We use it ourselves first, before reporting. So it is helping us to evaluate our work and measure what we've been doing and improve our services."

Dr. Irene Masawe,
Bugando Medical Center, Tanzania

The AIDSRelief Capacity Strengthening Approach

Capacity strengthening is essential to any organization's functioning. It includes capacity building, which focuses on individuals or teams, enhancing or developing new knowledge, skills, and attitudes in order to function better; institutional strengthening, focusing on an organization, enhancing or developing its systems and structures to function more effectively, work towards sustainability, and achieve goals; and accompaniment, which includes consistent

coaching, mentoring, and supportive supervision and allows new skills to be mastered or new organizational systems to become standard operating procedures. These tenets inspired AIDSRelief's program design and commitment to change: a transition from externally driven, vertical HIV treatment activities to locally owned, high-quality, integrated ART services delivered within a strengthened health system.

GROUNDING IN TRANSITION



Each AIDSRelief country program was designed to transition management to local ownership. AIDSRelief programs identified local partners with the potential to eventually sustain high-quality care and support for people living with HIV in their country. These partners were either health facility owners or existing local health networks that represented facility owners and were committed to providing facilities with long-term support.

As treatment systems were put into place, transition moved to the forefront and different understandings of transition and a local partner's role in that transition emerged among donor representatives, local partners, and within the consortium. Bringing these different perspectives into a unified vision—and beginning to make that vision a reality—was an enormous challenge.

In the early years of AIDSRelief, technical assistance to health facilities was intense. AIDSRelief strengthened staff and institutional capacity in grants management, strategic information, and clinical services by jointly identifying needs and providing direct, hands-on support to facility staff. Staff worked side-by-side for weeks at a time, and AIDSRelief technical teams were available around the clock. Together they transformed care delivery, rolling out high quality ART services in under-resourced facilities largely lacking experience with treatment.

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Transition planning intensified in 2009, and the agility and adaptability of AIDSRelief's global model allowed transition to take a different form in each country. Country-specific transition

"[That AIDSRelief was] 100 percent committed to transition was very motivating. We saw in our partner total commitment."

Karen Sichinga,
Executive Director,
Churches Health
Association of Zambia

plans guided capacity strengthening and incremental transfer of discrete responsibilities to ensure that supported sites provided uninterrupted quality services. Nevertheless, AIDSRelief maintained targeted technical assistance and site support, but also fostered relationships with and provided targeted capacity strengthening to indigenous health organizations and networks (faith-based and public).

By strengthening capacity in all aspects of these institutions (e.g., clinical, financial, strategic information, management) AIDSRelief helped prepare local partners to take full responsibility for supported sites and to manage grants effectively enough to become direct recipients of US government funding. As with facility staff, AIDSRelief combined didactic and hands-on training, ongoing mentorship and technical assistance, and supportive supervision to build capacity in a sustainable, meaningful way.

The transition process culminated in 2010 and 2011 as AIDSRelief transitioned some or all of the management of its care and treatment programs in all ten countries, while maintaining high-quality service delivery to patients in need. AIDSRelief provided capacity strengthening to each of these 19 partners and 14 of them (in eight countries) went on to secure new funding to manage care and treatment programs established through AIDSRelief.

In February 2010, AIDSRelief South Africa became the first PEPFAR care and treatment program to transition management responsibility to local partners, two years ahead of most other programs.

AIDSRelief Transition Partners

ETHIOPIA

Ethiopian Catholic Secretariat

GUYANA

Ministry of Health, Davis Memorial Hospital, St. Joseph Mercy Hospital

HAITI

St. Boniface Foundation

KENYA

Kenya Episcopal Conference, Christian Health Association of Kenya

NIGERIA

Christian Health Association of Nigeria, Catholic Caritas Foundation of Nigeria

RWANDA

Ministry of Health

SOUTH AFRICA

Southern African Catholic Bishops Conference, Institute for Youth Development – South Africa, St. Mary's Hospital

TANZANIA

Christian Social Services Commission, Weill Bugando University College of Health Sciences

UGANDA

Uganda Episcopal Conference, Uganda Protestant Medical Bureau

ZAMBIA

Churches Health Association of Zambia, Chreso Ministries





AIDSRelief's story is one of transformation; the program's impact is hard to overstate. Facilities that once could offer only rudimentary palliative care to patients in the last throes of an incurable disease now manage thousands of healthy, HIV-positive patients who raise families, participate in their communities, and contribute to their economies.

AIDSRelief helped local health systems absorb and grow stronger with the influx of financial, human, and material resources; helped local partners greatly expand their capacity to provide clinical oversight, effectively use data, and manage sites and direct funding from the U.S. government; and helped individual health facilities expand services to hundreds of thousands of people who once faced certain death.



Committed partnership and capacity strengthening were key to the program's excellent outcomes and its substantial progress toward a wholly locally-owned HIV response.

The AIDSRelief experience also demonstrated the importance of taking a health systems strengthening approach. In low-resource settings, HIV care and treatment programs require building not only clinical skills but also technical expertise in areas such as strategic information, grants management, community outreach, and supply chain. Strengthening organizations and institutions at all levels ensures that quality HIV programming exists within a sustainable health system.

"St. Mary's Hospital and its patients and their families have benefitted immeasurably from the AIDSRelief program. Thousands of patients who would otherwise have died are living productive lives with their families because of this program... The Hospital and AIDSRelief have learned a lot during this five-year journey together."

Dr. Douglas Ross, CEO St. Mary's Hospital, South Africa

ANNEX 1: AIDSRelief IN TEN COUNTRIES

COUNTRY	# SITES	Cumulative ever in care & treatment at transition	Cumulative ever on ART at transition	Current on ART at transition (incl. adults & peditrics)	Current peditrics on ART at transition
Ethiopia	5	4,125	2,179	1,062	144 (13.6%)
Guyana	3	2,443	1,519	1,083	74 (6.8%)
Haiti	11	14,644	6,473	4,469	306 (6.8%)
Kenya	31	141,734	88,615	60,549	6,320 (10.4%)
Nigeria	34	109,872	64,564	52,559	3,301 (6.3%)
Rwanda	20	11,928	6,698	4,850	670 (13.8%)
South Africa	28	73,293	35,038	21,204	1,518 (7.2%)
Tanzania	102	165,488	85,673	44,924	3,414 (7.6%)
Uganda	23	87,943	45,221	35,047	3,263 (9.3%)
Zambia	19	96,247	60,041	42,783	3,197 (7.5%)
TOTAL	276	707,717	396,021	268,530	22,207 (8.3%)

ACKNOWLEDGEMENTS



We would like to acknowledge the extraordinary support that AIDSRelief received from our donor, our local partners, staff and management at 276 local health facilities in ten countries

who gave their time and expertise to ensure that those most in need received—and will continue to receive—quality HIV care and treatment.

We thank the Office of the Global AIDS Coordinator for its commitment to supporting PEPFAR programs around the world. We are grateful for the financial and technical support from AIDSRelief’s donor, the Health Resources and Services Administration (HRSA), through funding from PEPFAR. We also appreciate the CDC teams in each country for their on-the-ground program oversight, guidance, and support.

The program’s impact would not have been possible without the tremendous dedication from all levels within the host country governments and with our local partners. Each and all were essential to AIDSRelief’s success and are helping make sustained country ownership possible.

We also wish to acknowledge the health workers and managers in health facilities and communities across the hardest hit areas of Africa, the Caribbean and Latin America. These often-unsung heroes and heroines of the HIV epidemic work under challenging circumstances and directly serve those in need. It has been an honor to work in partnership with them.



Thank you to the past and present staff of AIDSRelief, our local partners, and individual health facilities who agreed to be interviewed and share their experiences for this report. Lastly, thank you to the contributors to and reviewers of this report, whose thoughtful comments were invaluable.

